

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1223A Hebert Street		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1223A Hebert Street
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First OLLIE Middle Last LYNCH			4. DATE OF DEATH Month 12 Day 16 Year 60		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/2/1872	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Belleville, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Ambrose Jett		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Late Mitchell Lynch	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Mabel McMillin	Address 1223A Hebert Stret
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____ 420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **1950**, to **12-15-60** and last saw her alive on **12-15-60**
 Death occurred at **2:45 A. M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joe P. Berman M.D.	(Degree or title)	22b. ADDRESS 1225 - 40 Grand	22c. DATE SIGNED 12-16-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/19/60	23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Leidner Und. Co., 2223 St. Louis Ave.	ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 19 1960	26. REGISTRAR'S SIGNATURE Roan Smith. M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Albert M. Appfield

Licensed Embalmer No. *10307*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.